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The role of ethnicity in clinical psychopathology and care pathways of adults with intellectual disabilities

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ABSTRACT

The objective of this study was to explore whether people with intellectual disability from ethnic minority groups have higher rates of mental health problems and access different care pathways than their White counterparts. Clinical and socio-demographic data were collected for 806 consecutive new referrals to a specialist mental health service for people with intellectual disabilities in South London. Referrals were grouped according to their ethnic origin. The analyses showed that there was an over-representation of referrals from ethnic minority groups with diagnoses of schizophrenia spectrum disorder. In addition, Black participants were more likely to have an autistic spectrum disorder. Referrals of ethnic minority groups were considerably younger than White referrals, and less likely to be in supported residences. The results are discussed in the context of cultural and familial factors in particular ethnic groups that may play an important role in accessing and using mental health services.

1. Introduction

In the UK, some ethnic minority communities have been found to have an increased incidence of psychotic illness and access different care pathways to their White counterparts (Bhugra et al., 1997; Fearon et al., 2004, 2006; Morgan, Mallett, & Hutchinson, 2005). Various psycho-social and cultural factors have been suggested to explain such ethnic effects (e.g. Bhui & Bhugra, 2002; Gabel, 2004; Hutchinson et al., 1996; Ndetei & Vadher, 1984; Sharpley, Hutchinson, McKenzie, & Murray, 2001). It is important that clinicians and care providers are aware of such effects in order to promote equality and consistency within the mental health services.

Individuals with intellectual disabilities are at an increased risk of developing mental health problems including schizophrenia spectrum disorders (e.g. Cooper, Smiley, Morrison, Williamson, & Allan, 2007; Deb, Thomas, & Bright, 2001). Explanations for this increased vulnerability usually focus on the biological, cognitive, and social deficits that accompany intellectual disability, and how they may render an individual less able to deal with some of life's difficulties (Matson & Sevin, 1994). The role of ethnicity in individuals with intellectual disabilities is an area of increasing interest in recent years (McCarthy, Mir, & Wright, 2008), although there is little evidence on whether certain ethnic groups have an increased incidence of mental health problems and access different care pathways. The current study was designed to investigate whether the ethnic differences observed in severe mental illness in general adult mental health (Bhugra et al., 1997; Fearon et al., 2004, 2006; Morgan et al., 2005) were also present in a large sample of adults with intellectual disabilities.

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2. Method

2.1. Participants

We included all new referrals (806) to a specialist mental health service for adults with intellectual disabilities in South East London between 1984 and 2004. All participants fulfilled the eligibility criteria for intellectual disability of having an IQ below 70 and significant social impairment based on ICD-10 clinical criteria. Participants were grouped according to their ethnic origin into 3 main groups 'White', 'Black', and 'other non-White'. The 'Black' group consisted of Black Africans, African Caribbean and Black British. White British and White other were included into the White group. All others (including mixed race) went into the 'other' group. The reasons for doing this included the fact that, when considered separately, these ethnic groups had similar findings and so were grouped into these 3 broad groups, in order both to simplify the analysis and also to maximise statistical power. In the studied areas of South East London (boroughs of Lambeth, Lewisham and Southwark), the average population proportions by ethnic group are 63.8% White, 25.0% Black, and 11.2% other non-White (Census 2001, ONS). In assigning participants to ethnic groups we used a number of data sources. The primary source was self-ascribed ethnicity collected through the specifically designed form to gather socio-demographic information (Bouras & Drummond, 1989). When this information was not available other sources were used including other informants and case-notes.

2.2. Assessment

Data were collected on a specially designed form (Bouras & Drummond, 1989) to gather both clinical and socio-demographic information. Clinical diagnoses were made by a psychiatrist following clinical interviews with key informants and the patients as part of delivering a clinical service. Historical details of early social and communication problems were obtained from past medical records. Two experienced psychiatrists agreed independently on the diagnosis by using ICD-10 clinical criteria. The two clinicians were blind to the ethnicity of the patients. The degree of intellectual disability was coded on ICD-10 criteria into mild (F70), moderate (F71) or severe (F72–73), and the presence of autistic spectrum disorders by a diagnosis of pervasive developmental disorder (F84). Psychiatric diagnosis was coded to the following major ICD-10 categories: schizophrenia spectrum disorder (F20–27), personality disorder (F60–69), anxiety (F40–48), depressive disorder (F32–39), adjustment reaction (F43), and dementia (F00–03). In those referred from other mental health services with a provisional ICD-10 diagnosis (e.g. schizophrenia or autistic spectrum disorder) the assessing clinicians reviewed the diagnosis.

2.3. Analysis

Using the statistical package SPSS 15 for Windows, we performed chi-square (χ^2) tests to examine possible statistical significant differences in socio-demographic details, and psychiatric diagnoses between the three ethnic groups. In order to control statistically for the inter-relationship between socio-demographic and clinical variables, we performed a set of binary logistic regressions (Method: Enter). All the variables showing significant ethnic effects (on the basis of chi-square tests) were entered in the equation as binary covariates. Ethnicity group (*White*, *Black and non-White*) was as the dependant variable in all subsequent analyses.

3. Results

3.1. Socio-demographic data

Participants were between the ages of 16 and 86 years (mean = 33.6, SD = 13.6), of whom 60% were male and 40% were female. Table 1 shows the socio-demographic data obtained. Within each ethnic group, the number of participants is given according to their gender, age, source of referral, and place of residence.

No significant gender differences were observed between the ethnic groups ($\chi^2 = 1.41$, df = 2, $p > 0.10$). However there were statistically significant age differences ($\chi^2 = 69.09$, df = 8, $p < 0.0001$) with participants in the 'Black' and 'other' being relatively younger than in the 'White' group (about 50% <24 years). Significant ethnic differences were found in the source of referral ($\chi^2 = 14.85$, df = 6, $p = 0.02$) with a significantly lower proportion of White participants referred from the mainstream mental health services ($\chi^2 = 4.04$, df = 1, $p = 0.04$).

Significant ethnic differences were found in the place of residence, with a significantly higher proportion (63.6%) of 'other non-White' participants living in family homes ($\chi^2 = 8.08$, df = 2, $p = 0.02$). Also, 37.2% of the 'White' group were found to live in supported housing, compared to 29.0% of the 'Black' and 23.8% of the 'other non-White' groups ($\chi^2 = 6.68$, df = 2, $p = 0.03$). There were no other ethnic differences in place of residence.

3.2. Clinical data

Table 2 presents the proportion of participants within each group according to their degree of intellectual disability, the presence of autistic spectrum disorders, and their psychiatric diagnoses.